EFFINGHAM COUNTY HEALTH DEPARTMENT
VACCINE ADMINISTRATION RECORD

_____ _____

Client Name Date of Birth

For Clients: The following questions will help us determine which vaccines may be given today. If you answer "yes" to any, it does not necessarily mean the client should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

QUESTIONS	YES	NO
1. Is the client sick today?		
2. Does the client have allergies to medications, eggs, gelatins, neomycin, baker's yeast, latex or any vaccines?		
3. Has the client had a serious reaction to a vaccine in the past?		
4. Has the client, a sibling, or a parent had a seizure? Has the child or adult had any brain or other nervous system problems? Has the client had Guillian Barré Syndrome?		
5. Does the client or anyone who lives with the client or takes care of the client have cancer, leukemia, AIDS, or any other immune system problem?		
6. Has the client or anyone who lives with the client or takes care of the client taken cortisone, prednisone, other steroids, anticancer drugs (chemotherapy), radiation treatments or x-ray treatment in the past 3 months?		
7. In the past year has the client received a transfusion of blood or blood products immune globulin or an antiviral drug?		
8. For Females: Is the client pregnant or is there a chance she could become pregnant within the next three months?		
9. Has client received an immunization within the last 30 days or a TB skin test within the last 3 days?		

"I have read or have had explained to me the possible side effects and adverse reactions of the vaccines. I understand the benefits and risks of the vaccines and give permission for the vaccines be given to the client named above."

_____ _____ _____

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST Date
(Parent or Guardian)

Did you bring your immunization record card with you? ☐ Yes ☐ No

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask the healthcare provider to give you one with all your vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care. You will need this important document for the rest of your life to enter day care or school, for employment, or for international travel. **An additional charge may be assessed for copies of immunization records.**

If you are 4 years or older:

The Effingham County Health Department ask you to please wait 15 minutes, for safety reasons, after receiving vaccinations.

☐ **I agree to wait the 15 minutes.**
☐ **I choose not to wait and have been informed of the risks.**

_____ _____

Signature of Client/Parent **Date**

Client Name: _____ **D.O.B.:** _____

FOR OFFICE USE ONLY:

VACCINE ADMINISTRATION RECORD

VIS Given	Date	Vaccine	Manufacturer	Lot #	Site
	08/06/21	DTaP (Diptheria, Tetanus, Acellular Pertussis)			
	10/15/21	Hepatitis A			
	10/15/21	Hepatitis B			
	08/06/21	HIB (Haemophilus Influenzae)			
	08/06/21	HPV (Human Papillomavirus)			
	08/06/21	Influenza			
	08/06/21	Meningococcal (MCV4)			
	08/06/21	Meningococcal B			
	08/06/21	MMR (Measles, Mumps, Rubella)			
	08/06/21	MMRV (Measles, Mumps, Rubella, Varicella)			
	02/04/22	Pediatric Pneumococcal			
	02/04/22	Pneumococcal 20			
	08/06/21	Polio, Inacivated (IPV)			
	10/15/21	Rotavirus			
	08/06/21	Td (Tetanus, Diptheria)			
	08/06/21	Tdap (Tetanus, Diptheria, Pertussis)			
	08/06/21	Varicella (Chickenpox)			
	02/04/22	Zoster (Shingles)			
		DTaP- Hep B- IPV			
		DTaP- IPV- Hib			
		DTaP- IPV			

X = Given R = Refused Temp. _____ (Should be<99.6F)

_ _____Acknowledges that the questions have been reviewed. _____

Signature of Nurse Administering Vaccines Date

EZ: _____

IC: _____